Claims Clues

A Publication of the AHCCCS Claims Department March, 2002

Remit Identifies Required Medical Documentation

Effective April 1, the AHCCCS Claims Medical Review Unit will no longer routinely send billing providers a "Medical Documentation Request Form" when additional medical records are required to process a claim.

The Remittance Advice that is mailed to the billing provider lists the denial reason codes, and the code definitions are printed on the Processing Notes page. Medical Review denial codes are very specific and identify which documents are being requested.

Example: MD006 = Resubmit with discharge summary.

Providers must enter the Claim Reference Number (CRN) on the documentation so that it can be linked to the appropriate claim.

If the Medical Review Unit needs to make an unusual or complex request, the "Medical Documentation Request Form" will be used as in the past. □

Follow This Advice to Expedite Telephone Service from …

Claims Customer Service

Providers should be prepared to refer to their Remittance Advice when contacting the AHCCCS Claims Customer Service Unit with questions about a claim.

The Customer Service Unit has been experiencing a high volume of calls, and providers can help expedite the handling of their calls by being ready when the Customer Service representative comes on line.

Providers should be prepared to supply the following information:

- Caller's name
- AHCCCS provider ID number
- AHCCCS Claim Reference Number (CRN) of the claim in question

If the provider does not have the CRN of a claim, the provider should be prepared to supply the recipient's AHCCCS ID number and the date(s) of service for the claim in question.

The hours of operation are Monday through Friday, 7:30 am – 4:00 p.m. The Claims Customer Service Unit can be reached by calling:

- Phoenix area: (602) 417-7670 (Select option 4)
- In state: 1-800-794-6862, Ext. 77670 (Select Option 4)
- Out of State: 1-800-523-0231 □

Provider Registration

To help the AHCCCS Provider Registration Unit expedite the handling of telephone calls, callers should be prepared to supply the following information when contacting the unit:

- Caller's name
- AHCCCS provider ID number (if assigned)
- Telephone number (area code first)

Callers who do not have an AHCCCS provider number should be prepared to supply the following information:

- Caller's name
- Telephone number (area code first)
- Provider's Social Security Number or Tax ID Number

The hours of operation are Monday through Friday, 8:00 am – 4:00 p.m. Provider Registration can be reached by calling:

- Phoenix area: (602) 417-7670 (Select option 5)
- In state: 1-800-794-6862, Ext. 77670 (Select Option 5)
- Out of State: 1-800-523-0231 □

Anesthesia Must Be Billed in 15-Minute Units

Claims for anesthesia services must be billed to the AHCCCS Administration using 15-minute time increments as units of service.

Anesthesiologists and certified registered nurse anesthetists (CRNAs) must enter the appropriate ASA code (five-digit CPT procedure codes 00100 - 01999) in Field 24D and the total number of units in Field 24G of the HCFA 1500 claim form. One unit is a time increment of 15 minutes or any portion thereof.

The begin and end time of the anesthesia administration must be entered on the claim on the line following the ASA code. The number of units billed must not exceed the time period expressed by the begin and end time.

For example, if the begin time of anesthesia administration is 1:00 p.m. and the end time is 3:05 p.m., the provider should bill nine units:

1:00 – 2:00 = 4 units
2:00 – 3:00 = 4 units
3:00 – 3:05 = 1 unit
Total = 9 units

If the units billed exceed the maximum allowed for the procedure, the AHCCCS system will cut back the units to the maximum allowed. The claim will pend to Medical Review to determine if the additional units are appropriate.

Although the policy outlined above is currently in effect, AHCCCS is examining alternative methods of billing for anesthesia services.

The next issue of *Claims Clues* will include a survey that will allow providers to express their opinions about options for billing anesthesia services. ☐

Supplemental Documents Must Identify Claim CRN

Providers who submit supplemental documentation to the AHCCCS Administration after submitting a claim form must identify the claim to which the documentation is to be linked in the AHCCCS Claims Processing System.

Providers should indicate the appropriate Claim Reference Number (CRN) on the supplemental documentation.

If the supplemental documentation is to be linked to a claim that has been denied, providers must add an "A" in front of the CRN. This will alert AHCCCS that the claim must be reopened and the documentation routed to the correct location (e.g., Medical Review) for adjudication.

Otherwise, the documentation will be linked to the already denied claim, and it will remain denied.

These guidelines apply to claims submitted on paper and also electronically.

Questions about claim submission should be directed to the AHCCCS Claims Customer Service Unit at:

- Phoenix area: (602) 417-7670 (Select option 4)
- In state: 1-800-794-6862, Ext. 77670 (Select Option 4)
- Out of State: 1-800-523-0231) ❐

Hospital Procedure, Diagnosis Billing Rules Clarified

Hospital billers should ensure that the primary ICD-9 procedure is entered in the Principal Procedure field (Field 80) of the UB-92 claim form when submitting fee-for service claims to the AHCCCS Administration.

If the primary procedure is entered in any of the Other Procedure fields (Field 81) and the code entered in Field 80 identifies a non-covered procedure, the claim may be denied.

When billing for recipients eligible under the Emergency Services Program (ESP), hospital billers should ensure that the diagnosis code entered in the Admitting Diagnosis Code field (Field 76) clearly identifies the ESP recipient's emergent condition.

Claims for ESP recipients are reviewed by AHCCCS on a case by case basis. Claims must be submitted with documentation that supports the emergent nature of the services provided. ☐